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Massachusetts Total Medical Expenses: 2009 Baseline Report

Executive Summary

June 2011



DIVISION OF
Health Care
Finance and Policy

Introduction

Pursuant to the provisions of M.G.L. c. 118G, § 6, the Massachusetts Division of Health Care Finance and Policy (DHCFP) is required to promulgate regulations for the uniform calculation and reporting by payers of health status adjusted total medical expenses (TME) and to publicly report that data. In this report, DHCFP examines how total health care expenditures for member populations vary by carrier, region, income, primary care physician group, and participation in a managed or non-managed care plan. For this analysis, DHCFP analyzed TME data reported by payers for calendar year 2009.¹

TME is defined as the total health care expenditures for a member population based on allowed claims for all categories of medical expenses and all non-claims related payments to providers. TME is always expressed on a per member per month (PMPM) basis.

More simply, TME measures the total spending on medical care for a covered population. Medical spending is based on insurer payments, including outlier payments and non-claims payments to health care providers such as pay for performance amounts and risk-sharing capitation settlements, as well as member cost-sharing. TME incorporates both service price and service volume, as it includes all payments for medical care made on behalf of members.²

Unadjusted and Health Status Adjusted TME

TME can be measured on an unadjusted basis which reflects actual spending but does not consider differences among member populations. TME may also be adjusted to reflect differences in member health status such as age, gender, and clinical profile. This report presents both unadjusted and health status adjusted TME data.

Unadjusted TME is presented for aggregated analyses across payers, such as statewide and regional analyses. Unadjusted TME had to be used for such purposes since payers in this analysis utilized different health status adjustment products.

Health status adjusted TME is analyzed in order to compare health care expenditures of different member populations within a payer's membership. TME is presented on a health status adjusted basis for payer-specific regional analysis, managed and non-managed populations, and primary care physician groups within a payer's network.

¹ TME data was analyzed from Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Neighborhood Health Plan, and Tufts Health Plan. These five payers account for approximately 66% of Massachusetts covered lives. However, some data was excluded as it did not capture complete medical spending. Full claims data included in the TME analyses represents approximately 52% of Massachusetts privately covered lives.

² Since TME is the result of both price and utilization, it is not possible to uncouple the influence of either one directly. However, recent research has indicated that higher prices were the primary driving factor in increased privately insured health care spending from 2007 to 2009. See Division of Health Care Finance and Policy, Trends in Health Expenditures, June 2011, available at: http://www.mass.gov/Eoehhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf, accessed 6/19/2011.



Key Findings

- **Massachusetts statewide unadjusted total medical expenses in the commercial market were \$403 PMPM in 2009.** Hospital inpatient and outpatient services accounted for 41% of unadjusted total medical expenses, while physician services represented 28%, followed by spending for prescription drugs at 17%. The balance of spending went towards non-physician professional services (5%), other medical expenses (5%), and non-claims payments including performance incentive payments and capitation risk settlements (4%).
- **There is significant variation in unadjusted TME by payer, ranging from \$356 PMPM for Neighborhood Health Plan to \$412 PMPM for Blue Cross Blue Shield of Massachusetts.** Unadjusted TME represents actual spending, and the reason for these variations requires further analysis. Among the potential contributing factors include differences in the health status of members, the geographic residence of members, utilization differences, provider network, and different payment rates and methods.
- **There are considerable differences in TME by geographic area, based on member residence.** At the regional level, unadjusted TME ranged from \$372 PMPM in central Massachusetts to \$426 PMPM in the North Shore region, a variation of nearly 15%.³
- **There is a correlation between health status adjusted average TME for the residents of a city and the median income of that city.**
- **The health status adjusted TME of members in managed care plans was higher than TME for non-managed members for Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care and virtually identical for Tufts Health Plan.** It is important to note that unadjusted total medical expenses per member were higher for non-managed members than managed members across all payers in this analysis. The significant impact of health status adjustment on TME suggests that the non-managed population is generally less healthy and requires greater medical resources than the managed population.

³ For individual cities and towns with at least 3,000 members, health status adjusted TME varied by as much as 60% for Blue Cross Blue Shield of Massachusetts (from a low of \$305 in Holyoke to \$489 in Watertown), 27% for Harvard Pilgrim Health Care (from a low of \$353 in Lowell to \$450 in Brookline), and 28% for Tufts Health Plan (from a low of \$337 in Lowell to \$431 in Newton).



- **There is significant variation in health status adjusted TME across primary care physician groups, with a difference of 55% among physician groups in one payer's network.**
- **Several primary care physician groups tended to have relatively higher or relatively lower TME across multiple payer networks.** Physician local practice groups with higher TME across payer networks had higher spending in every service category, with the greatest differences between the higher and lower groups in spending for hospital outpatient and physician services. Hospital outpatient spending was \$36 PMPM or 43% greater for higher relative TME practice groups than for lower relative TME practice groups. Spending for physician services was \$19 PMPM or 18% greater for higher relative TME physician groups than for lower relative TME physician groups.
- **The number of managed care members at a parent physician group does not appear to be correlated with the level of physician group TME on a PMPM basis.** This suggests that larger or smaller membership is not a significant factor in explaining variations in medical spending.
- **Health plan membership is disproportionately concentrated at physician local practice groups with higher TME.** Two of the three largest payers had more than half of their managed care members at physician local practice groups with health status adjusted TME above the median for all physician groups. This concentration of membership at physician groups with relatively high TME likely contributes to higher overall medical spending on a statewide level.

These baseline analyses suggest that total medical expense is potentially a useful measure for understanding and monitoring health care spending in Massachusetts. The significant variation in TME identified across geographic regions and primary care physician local practice groups suggest that there are opportunities to reduce health care spending in Massachusetts. It is critical that Massachusetts health care stakeholders identify the factors that cause variation in medical expenses and implement effective strategies to moderate spending.





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